PINNACLE
HEALTHCARE SYSTEM

PATIENT INFORMATION SHEET

**PATIENT INFO: LAST NAME**_____**FIRST**_____ **MI**____

**SEX M F D.O.B.** _____/_____/_____ **SS#** _____/_____/_____ **CIVIL STATUS** MARR DIV SING W SEP

**ADDRESS**_____**CITY**_____**ST**_____**ZIP**_____
**PHONE**
**HOME**_____**WORK**_____**CELL**_____

**PREFERRED PHONE METHOD** _____ **EMAIL** _____

**Can we leave a voice message regarding upcoming appointments on your home or cell phone?** _____YES ____NO

**Would you like to receive communication regarding your appointments via text message** _____YES ____NO

**Or Email** _____YES ____NO

**Race:**
_____ **American Indian or Alaska Native**
_____ **Asian**
_____ **Native Hawaiian or Other Pacific Islander**
_____ **White**
_____ **Black or African American**
_____ **Hispanic**
_____ **Other Pacific Islander**
_____ **Other Race**
_____ **Prefer Not To Answer**

**Ethnicity :** _____**Hispanic or Latin** _____ **Not Hispanic or Latin** _____ **Prefer Not To Answer**

**Preferred Language:** _____ **English** _____ **Spanish** _____ **Other** _____

**EMPLOYER**_____**ADDRESS**_____

**WHO IS YOUR PRIMARY CARE PHYSICIAN**_____**PHONE** _____

**PREFERRED PHARMACY**_____ **ADDRESS**_____

**PHARMACY PHONE**_____

**IN CASE OF EMERGENCY, WHOM SHOULD WE CONTACT? (*YOU MUST FILL THIS OUT*)**

**NAME**_____ **RELATIONSHIP** _____

**ADDRESS**_____**CITY**_____**ST**_____**ZIP**_____
**PHONE**
**HOME**_____**WORK**_____**CELL**_____

**<u>GUARANTOR INFO: (WHO IS RESPONSIBLE FOR THE BILL?)</u>**

**LAST NAME**_____ **FIRST**_____ **MI**_____

**SEX M F D.O.B.** _____/_____/_____ **SS#** _____/_____/_____ **CIVIL STATUS** MARR DIV SING W SEP

**ADDRESS**_____**CITY**_____**ST**_____**ZIP**_____
**PHONE**
**HOME**_____**WORK**_____**CELL**_____

**PRIMARY INSURANCE INFORMATION**

**INS. CO. NAME**_____

**INS ADDRESS**_____

**INS PHONE NO.** _____

**SECONDARY INSURANCE INFORMATION**

**INS. CO. NAME**_____

**INS ADDRESS**_____

**INS PHONE NO.** _____

**GROUP NO. _____ID _____** **GROUP NO. _____ID _____**

**NAME OF INSURED_____** **NAME OF INSURED_____**

**INSURED'S SOCIAL _____-_____--_____** **INSURED'S SOCIAL _____-_____--_____**

**WOULD YOU LIKE TO FILL OUT A LIVING WILL OR NAME A PROXY IN CASE OF EMERGENCY?** YES NO

If there is someone that you would like to authorize to receive medical information about you, please fill out below:

I hereby authorize Pinnacle Healthcare System to release medical information about me to:

NAME _____RELATIONSHIP_____

**ASSIGNMENT OF BENEFITS**

I hereby assign payment directly to Pinnacle Healthcare System (PHS) accepting assignment of medical benefits applicable and otherwise payable to me. I understand that I am financially responsible to PHS for charges not covered by this assignment or for any and all charges which the insurance carrier declines to pay. It is further agreed that any credit balance resulting from payment of insurance or other sources may be applied to any other accounts owed to PHS by the insured.

**RELEASE OF INFORMATION**

PHS may disclose all or part of the patients record to any person or corporation which is or may be liable under a contract to the physician or to the patient or to a family member or employer of the patient for all or part of PHS charges, including, but not limited to, insurance companies, workers compensation carriers, welfare funds, or the patient's employer.

**HMO DISCLAIMER**

I certify that I _____ am ____ am not presently enrolled in any Health Maintenance Organization (HMO). Subsequent rejection of a claim as a result of this procedure due to current enrollment in a HMO Plan will constitute responsibility for payment of claim on my part.

**MEDICARE AND MEDICAID PATIENT CERTIFICATION - PATIENTS CERTIFICATION, AUTHORIZATION TO RELEASE INFORMATION AND PAYMENT REQUESTS**

I certify that the information given by me in applying for payment under Title XVIII and /or Title XIX, of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediary carriers any information needed for this or a related Medicare/Medicaid claim. I request that payment of authorized benefits be made on my behalf and I assign the benefits payable to PHS. I understand that I am responsible for any health insurance deductible and coinsurance.

**FINANCIAL AGREEMENT**

The undersigned agrees, whether he/she signs as agent or patient, that in consideration of the services to be rendered to the patient, he/she individually obligates himself/herself to pay the account in accordance with the regular rates and terms. Should the account be referred to a collection agency and/or an attorney for collection, the undersigned shall pay reasonable attorney's fees and collection expenses.

I am responsible for payment myself because: ___Procedure/Visit not covered by insurance ___I do not have health insurance

_____ _____
Name Of Patient (please print) Name Of Witness (please print)

_____ _____
Signature of Patient Signature of Witness

_____ _____
Patients Agent or Representative Date

Patient was unable to sign due to: _____

_____ _____
Signature of Witness Policy Holders Signature (If other than patient)